# PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

# DIRECTIONS TO CLAIMANT

Dear Claimant

To make a claim for a benefit under the policy you must read this document carefully and ensure that you understand what is required of you. Should you have any questions on what to do or how to submit your claim you should contact us on the above numbers. Before you complete any forms you must ensure that you have read the policy document thoroughly and that the relevant cover exists under the policy.

You must be aware that any omission or misstatement on the forms may lead to the claim being declined. You or any other person completing the forms must do so as honestly and truthfully as possible. You must make sure that you provide as much details as possible when answering the questions. In the case of a deliberate omission or misstatement that may influence the outcome of the claim, a case of fraud may also be instituted against yourself or the person completing the form. You must also convey this to the doctor or employer when completing the forms.

You must ensure that you have enclosed copies of all relevant reports and documents, as failure to do so may delay the processing of the claim. Where we have requested copies of medical reports or laboratory and other results, it is your responsibility to ensure that these are forwarded to us. Once we have reviewed the claim we may request additional information. It is your responsibility to forward us that information as quickly as possible. No decision may be made on a claim if any requested information is outstanding.

Below we have illustrated a table of what forms must be completed. We have also indicated what other documents must be submitted with your claim. Please ensure that you submit completed and signed copies of all the forms requested, and all the documents required. Where unable to do so please advise us of the reason/s to enable us to assist, give further instructions / assistance.

Once we have received the initial claim documentation we will inform you of any further requirements or our decision. You must be aware that the completion of any forms and the submission of a claim in no way constitute an admission of liability on the insurer.

Kindly return personal statement within 30 days of notification and all other documents as soon as possible. We thank you for your assistance in this matter.

| Forms Required | Death Benefit |
|---|---|
| Declaration of Consent | X |
| Medical Report General Practitioner / Specialist | X |
| Personal Statement Claimant (Death) | X |

| Documents Required | Death Benefit |
|---|---|
| Certified copy of Identity Document (Claimant & Policy Holder) | X |
| Legal Standing to claim (E.G. Appointed Executor / Letter of Authority) | X |
| Results of all special investigations medical | X |
| Certified copy of Death Certificate | X |
| Certified copy of BI 1663 / Death Notification | X |
| Unnatural – Police Report / Inquest Report | X |
| Accident report if Vehicle Accident | X |
| Comprehensive insurer details if Vehicle Accident | X |
| Alcohol / Drug Test results | X |
| Unnatural - Autopsy Report / Post Mortem | X |
| Unnatural – Copy of the Verdict & Sentence in case of criminal trial. | X |
| Unnatural – Full Inquest proceeding plus all statements & other evidence. | X |

| Finance Documents Required | Death Benefit |
|---|---|
| Contract / Installment Sale / Lease Agreement | X |
| Detailed Statement | X |
| Amortisation / Repayment Schedule | X |
| Dealers tax Invoice | X |
| Application for Finance | X |

PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

# Declaration of Consent

## Policyholder's Personal Details

Name & Surname: _____

Date of Birth: | D | D | M | M | Y | Y | ID No: _____

Policy No: _____

Medical Aid: _____ Medical Aid No: _____

To facilitate the assessment of the risk and the consideration of any claim for benefits, under the aforementioned policy I irrevocably authorize PinnAfrica to obtain from any person, institution or organization, any information which PinnAfrica deems necessary for the assessment of my claim.

I hereby authorize any medical practitioner, hospital, institution, pharmacy, my employer, my medical aid scheme or any other person who has any information of whatsoever nature relating to my health, to provide such information to an authorized representative of PinnAfrica who requires this information for the purposes of assessing my claim.

I hereby authorize PinnAfrica to release or disclose any medical information relating to my health and my claim to any party who may require such information for the purposes of assessing my claim for benefits.

I further indemnify the aforementioned party / parties and the insurer against any loss, damage or injury that I may incur in any manner whatsoever, directly or indirectly, as a result of disclosing such information

_____ _____

Policy Holder Signature Date

or

_____ _____

Duly Authorized Signatory / Next of Kin Date

_____ _____

Full Name of Authorised Signatory / Next of Kin Relationship to claimant

# PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

# MEDICAL REPORT FOR DEATH CLAIM

Dear Doctor,

The deceased's family is applying for insurance benefits in respect of the deceased's death. In order to assess the claim we require your assistance in providing us with the relevant medical information relating to the circumstances surrounding the death. Please complete the questions below truthfully and to the best of your knowledge, providing as much detail as possible. Copies of all special tests and investigations performed during the course of treatment must be attached and forwarded together with this form. Please also enclose a copy of the Death Certificate, BI 1663 Death Notification form, and Autopsy / Postmortem report if available. The deceased's family is anxious to receive a response regarding the claim, please return the completed form to us at your earliest convenience.

Thank you for your assistance.

## 1. MEDICAL PRACTITIONER'S DETAILS

Name of Doctor: _____ Practice No: _____

Postal Address: _____

Telephone No: _____ Fax No: _____

E-mail Address: _____ Qualifications: _____

Since which date have you been the clients treating GP: | D | D | M | M | Y | Y |

When was the last time you consulted the deceased prior? | D | D | M | M | Y | Y |

## 2. DECEASED'S PERSONAL DETAILS

Deceased's name & Surname: _____

Date of Birth: | | | | | | | ID No: | | | | | | | | | | | | | |

Policy No: _____ Date of Death: | D | D | M | M | Y | Y |

Place of Death: _____

Hospital / Patient / File Number if death occurred in hospital: _____

Residential Address: _____

Medical Aid: _____ Medical Aid No: _____

## 3. DETAILS OF DEATH

3.1 What was the primary cause of death?

_____

_____

3.2. When was the date of onset of the primary condition and when was the diagnosis made?

_____

_____

3.3. What was the immediate cause of death?

_____

_____

3.4. When was the date of onset of the immediate cause of death and when was the diagnosis made?

_____

_____

3.5. If the cause of death was due to unnatural causes please provide a description and details of the event:

_____

_____

_____

3.6. Was an inquest held? If yes, please provide the Inquest / Docket Number and the name of the police station handling the inquest:

_____

_____

3.7. Were there any contributing factors to the death, including any previous illnesses, family history, injuries, trauma, and personal habits including the use of narcotics or alcohol and hazardous pursuits?

_____

_____

3.8. Did the deceased ever receive medical attention or advice to reduce liquor, substance abuse or tobacco or was there a history of change of consumption or use? If “yes” please provide full details.

_____

_____

3.9. Were you the person who notified the death? If no, please provide the name of the relevant person if known:

_____

_____

3.10. Was an autopsy / postmortem performed. Please provide the name of the forensic laboratory / mortuary where it was performed and enclose a copy of the report if available:

_____

_____

## 4. DECEASED'S CONSULTATION HISTORY

4.1. Please provide details of all other consultations with the deceased, whether or not the reason for consultation was related to the cause of death:

| Date | Reason for Consultation | Diagnosis | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*Should you require additional space please continue on a separate sheet*

4.2 Please state the names and dosages of all medication that the deceased was using prior to death:

_____

_____

_____

_____

4.3 Did the deceased ever test positive for HIV antibodies? YES | NO

4.3.1 What was the diagnosis date? Please enclose a copy of the test results. D D M M Y Y

4.3.2 Was the condition contracted through accidental exposure? If yes, please provide details.

_____

_____

4.4 Please provide the details of any other Practitioners, Specialists or Hospitals to whom the deceased had been referred, either in relation to the cause of death or for any other condition. Please include copies of all available Specialist reports.

| | | | |
|---|---|---|---|
| **Name of Practitioner / Hospital** | | | |
| **Specialty** | | | |
| **Contact Number** | | | |
| **Patient / File Number** | | | |
| **Address** | | | |
| **Complaints referred for** | | | |

## 5. ADDITIONAL INFORMATION

5.1. Is there any other information which in your opinion may assist us in assessing this claim:

_____

_____

_____

_____

_____

_____

_____

_____

_____

## 6. D E C L A R A T I O N

**I hereby declare that I have been the deceased's attending medical doctor and warrant that the content of this report is true and correct to the best of my knowledge, and that no information which may influence the outcome of this claim has been withheld or omitted.**

Doctor's Signature:_____ Date: d d m m y y

# PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

# MEDICAL REPORT FOR DEATH CLAIM

Dear Doctor,

The deceased's family is applying for insurance benefits in respect of the deceased's death. In order to assess the claim we require your assistance in providing us with the relevant medical information relating to the circumstances surrounding the death. Please complete the questions below truthfully and to the best of your knowledge, providing as much detail as possible. Copies of all special tests and investigations performed during the course of treatment must be attached and forwarded together with this form. Please also enclose a copy of the Death Certificate, BI 1663 Death Notification form, and Autopsy / Postmortem report if available. The deceased's family is anxious to receive a response regarding the claim, please return the completed form to us at your earliest convenience.

Thank you for your assistance.

## 1. MEDICAL PRACTITIONER'S DETAILS

Name of Doctor: _____ Practice No: _____

Postal Address: _____

Telephone No: _____ Fax No: _____

E-mail Address: _____ Qualifications: _____

Since which date have you been the clients treating GP: | D | D | M | M | Y | Y |

When was the last time you consulted the deceased prior? | D | D | M | M | Y | Y |

## 2. DECEASED'S PERSONAL DETAILS

Deceased's name & Surname: _____

Date of Birth: | | | | | | | ID No: | | | | | | | | | | | | | |

Policy No: _____ Date of Death: | D | D | M | M | Y | Y |

Place of Death: _____

Hospital / Patient / File Number if death occurred in hospital: _____

Residential Address: _____

Medical Aid: _____ Medical Aid No: _____

## 3. DETAILS OF DEATH

3.1 What was the primary cause of death?

_____

_____

3.2. When was the date of onset of the primary condition and when was the diagnosis made?

_____

_____

3.3. What was the immediate cause of death?

_____

_____

3.4. When was the date of onset of the immediate cause of death and when was the diagnosis made?

_____

_____

3.5. If the cause of death was due to unnatural causes please provide a description and details of the event:

_____

_____

_____

3.6. Was an inquest held? If yes, please provide the Inquest / Docket Number and the name of the police station handling the inquest:

_____

_____

3.7. Were there any contributing factors to the death, including any previous illnesses, family history, injuries, trauma, and personal habits including the use of narcotics or alcohol and hazardous pursuits?

_____

_____

3.8. Did the deceased ever receive medical attention or advice to reduce liquor, substance abuse or tobacco or was there a history of change of consumption or use? If “yes” please provide full details.

_____

_____

3.9. Were you the person who notified the death? If no, please provide the name of the relevant person if known:

_____

_____

3.10. Was an autopsy / postmortem performed. Please provide the name of the forensic laboratory / mortuary where it was performed and enclose a copy of the report if available:

_____

_____

## 4. DECEASED'S CONSULTATION HISTORY

4.1. Please provide details of all other consultations with the deceased, whether or not the reason for consultation was related to the cause of death:

| Date | Reason for Consultation | Diagnosis | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*Should you require additional space please continue on a separate sheet*

4.2 Please state the names and dosages of all medication that the deceased was using prior to death:

_____

_____

_____

_____

4.3 Did the deceased ever test positive for HIV antibodies? YES | NO

4.3.1 What was the diagnosis date? Please enclose a copy of the test results. D D M M Y Y

4.3.2 Was the condition contracted through accidental exposure? If yes, please provide details.

_____

_____

4.4 Please provide the details of any other Practitioners, Specialists or Hospitals to whom the deceased had been referred, either in relation to the cause of death or for any other condition. Please include copies of all available Specialist reports.

| | | | |
|---|---|---|---|
| **Name of Practitioner / Hospital** | | | |
| **Specialty** | | | |
| **Contact Number** | | | |
| **Patient / File Number** | | | |
| **Address** | | | |
| **Complaints referred for** | | | |

## 5. ADDITIONAL INFORMATION

5.1. Is there any other information which in your opinion may assist us in assessing this claim:

_____

_____

_____

_____

_____

_____

_____

_____

_____

## 6. D E C L A R A T I O N

**I hereby declare that I have been the deceased's attending medical doctor and warrant that the content of this report is true and correct to the best of my knowledge, and that no information which may influence the outcome of this claim has been withheld or omitted.**

Doctor's Signature:_____ Date: d d m m y y

# PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

# PERSONAL STATEMENT CLAIMANT - DEATH

Dear Applicant,

If you are making an application for a death benefit on behalf of a deceased policy holder you are required to complete this form as truthfully and in as much detail as possible. The person making this application must be duly authorized to do so. Before you complete this form you must ensure that you have thoroughly read the document marked "Directions to Claimant". Any misstatement in this form may be used as grounds for the claim not being admitted. You must attach copies of all medical reports, including results of blood tests, x-rays, histology and laboratory reports relating to the deceased's health prior to and leading up to the time of death. You must also enclose certified copies of the deceased's Identity Document, Death Certificate, BI 1663 Death Notification and Autopsy report. If the death was as a result of unnatural causes you must also enclose a copy of the Police / Inquest report. Failure to enclose these reports may result in a delay in your claim. You must be aware that completing this form in no way constitutes an admission of liability on the insurer.

## 1. YOUR DETAILS

Title & Full Name: _____

ID No: | | | | | | | | | | | | | |

Residential Address: _____

_____

Postal Address: _____

_____

Your contact details: Home Tel: _____ Work Tel: _____
Fax No: _____ Cell: _____
Email: _____

What is your relationship to the deceased? _____

## 2. DECEASED'S DETAILS

Deceased's name & Surname: _____

Date of Birth: | | | | | | | ID No: | | | | | | | | | | | | | |

Policy No: _____ Date of Death: D D M M Y Y

Place of Death: _____

Hospital / Patient / File Number if death occurred in hospital: _____

Residential Address: _____

Medical Aid: _____ Medical Aid No: _____

Marital Status: _____ No. of Dependants: _____

## 3. DETAILS OF DEATH

3.1. Was the death due to Natural or Unnatural causes? _____

3.2. Please provide a description of the illness / injury / trauma that resulted in the deceased's death, and the date of onset:

_____

_____

_____

_____

3.3. Please state the name and contact details for the doctor who treated the deceased at the time of death:

_____

_____

3.4. Please state the name and contact details for the deceased's usual family doctor for the last five years:

_____

_____

3.5. If the death was due to Unnatural causes please proved a description of the event / incident that resulted in the deceased's death:

_____

_____

_____

3.5.1 What is the Police / Inquest number: _____

3.5.2 Please provide contact details for the police station where the inquest was conducted:

_____

_____

3.6. Please provide the details of any other Practitioners, Specialists or Hospitals whom the deceased consulted in the last five years, either in relation to the cause of death or for any other condition. Please include copies of all available Specialist reports.

| | | | |
|---|---|---|---|
| **Name of Practitioner / Hospital** | | | |
| **Specialty** | | | |
| **Contact Number** | | | |
| **Patient / File Number** | | | |
| **Address** | | | |
| **Complaints** | | | |

*Should you require additional space please continue on a separate sheet*

3.7. Was an autopsy / postmortem performed: _____

3.7.1 Please provide the contact details for the forensic laboratory / mortuary where the autopsy was done:_____

_____

## 4. FINANCE COMPANY

**THIS SECTION IS TO BE COMPLETED BY THE FINANCE COMPANY**

4.1. Finance agreement number:_____

4.2. Inception date of agreement: d d m m y y

4.3. Date agreement was due to end: d d m m y y

4.4. Length of agreement:_____

4.5. Total amount to be paid off:_____

4.6. Amount owing on the loan:_____

FINANCE COMPANY'S STAMP

Name of signatory: _____ Position Held: _____

Signature: _____ Date: d d m m y y

## 5. NOMINATED POWER OF ATTORNEY / APPLICANT' S DECLARATION

**DECLARATION**

**I hereby declare that all the particulars given on this claim form are to the best of my knowledge true and correct, and that no material information has been withheld or omitted.**

**I hereby authorise any medical practitioner, hospital or any other person who has information about the deceased's health cause of death to provide such information to Pinnafrica or any party nominated by Pinnafrica.**

_____ d d m m y y

**NOMINATED POWER OF ATTORNEY / APPLICANT'S SIGNATURE** **DATE SIGNED**

# PinnAfrica

Insurance Underwriting Managers

Block A, 1st Floor, The Ambridge Office Park, 1 Vrede Avenue, Epsom Downs, Douglasdale, 2021
PO Box 98758, Sloane Park, 2152 – Tel: 010 007 0069 – Fax: 086 415 6308
Email: claims@pinnafrica.co.za – Website: www.pinnafrica.co.za
PinnAfrica Insurance Underwriting Managers (Pty) Ltd. (2007/035443/07). FSP Number 39123
Directors: NC Du Piesanie, N Wearne, JJ Pearson
Non-executive Director: K Sicwebu

## TO BE COMPLETED BY THE INVESTIGATING OFFICER AND WILL BE CONSIDERED STRICTLY CONFIDENTIAL

This report is required to assess a death claim under a policy issued by PinnAfrica on the life of:

Police Station where death was reported? _____

Case Number: _____ Investigating Officer: _____

Name of Deceased (In Full): _____

Deceased ID Number / Date of Birth | | | | | | | | | | | | | |

Date, Time & Place of Death _____

Please indicate circumstances of Death by tick – If driver, did insured hold a valid licence? YES | NO

Motor Vehicle Accident? Driver: ☐ Passenger / Pedestrian: ☐

Assault? Murder: ☐ Unknown / Still Investigating: ☐

Is there any suspicion that the deceased committed suicide? YES | NO

Was a blood-alcohol test done on the deceased? YES | NO If yes, taken at? Scene | Post-Mortem

Please provide Circumstances of Death: _____

Was a Post Mortem held? (If yes, please attach a copy) YES | NO

If Post Mortem unavailable, please provide reference number: _____

Has there or will there be an inquest? YES | NO

If YES, please advise:

1) Date of Inquest? D D M M Y Y

2) Inquest/Reference Number: _____

3) If available, please enclose copy of the Inquest Report.

4) Where inquest report not available, please supply details of case: _____

Have criminal proceedings been or will criminal proceedings be instituted? YES | NO

If yes, What was the charge? _____ Who was charged? _____

If judgement has been given, the verdict? _____

Is there any suspicion or probability of family involvement in the death? YES | NO

Name of Court? _____

Date of Trial: D | D | M | M | Y | Y

Trial number & reference _____

**Signed at:** _____ **On This:** _____ **Day of:** _____

**Signature of investigating Officer:**

**Name and Rank:**

**Telephone number (Code):**

**Fax Number**

Police Station Stamp

**This form to be returned in confidence to:**


**PinnAfrica**
**Insurance Underwriting Managers**

**Claims Department**
**Tel: 010 007 0069 / 011 047 4400**
**Fax: 086 415 6308**
**E – Mail: bmwclaims@pinnafrica.co.za**